# SOUTH CAROLINA DEPARTMENT OF DISABILITIES & SPECIAL NEEDS

## Pervasive Developmental Disorder Program
## Early Intensive Behavior Intervention Consultant Recertification Application

Please complete this application and return it to the address below by **the 15th of the month in which your certification expires.** This application is required for all Qualified Providers who wish to continue providing Consultant level EIBI services through the PDD Waiver/State Funded Program. Failure to accurately complete and submit this application by the due date will result in you being suspended as a Consultant until these requirements are met. Individuals will not be compensated for Consultant level work while suspended. Reinstatement will require written notification from the Autism Division. If a Consultant is Board Certified (BCBA or BCABA) their expiration date will be based on the date at which their board certificate expires. If a Consultant is not Board Certified (Tier 3) their expiration date will be based on the date at which they became an enrolled EIBI provider (i.e. the date indicated on the enrollment notification letter from DHHS). Currently, these terms are every three (3) years.

1. Consultant Name: _____

2. Certification Type: BCBA _____ BCABA _____ Tier 3 _____

3. Certification Number: _____ 4. Date Issued: _____

5. Employer Name and Mailing Address: _____

   _____

6. Contact Information: Email Address (**Please Print Clearly)** _____

   Work Telephone Number: _____ Fax Number: _____

**Keep a copy of this application for your records.**

**Do not send continuing education documents with this Recertification Application.** You must retain documentation (certificates, course outlines, grade reports, etc.) of continuing education units you claim for each year.

**MANDATORY QUESTIONS AND ATTESTATIONS**

You must complete all questions.

1. Have you read, are you in compliance with, and do you agree to continued compliance with all Pervasive Developmental Disorder Waiver/State Funded Program rules and regulations that pertain to Early Intensive Behavior Intervention (EIBI) providers, as may be revised, including, but not limited to the PDD Program Consultant continuing educational requirements, personnel protocol, billing procedures, and training (Line Therapists and work groups) requirements?

**YES_____ NO_____ "NO" responses will not be processed.**

2. Do you have a physical or mental condition or addiction to any substance that could impair competent and objective professional performance of EIBI Consultant services and/or jeopardize the health and safety of the EIBI consumers you serve?

   **YES_____ NO_____ Attach an explanation for "YES" responses**.

3. Have you been subject to an investigation or disciplinary action by a health care organization, professional association, governmental entity or regulatory or licensing agency/authority, and/or have you ever been convicted, found, or entered a plea of guilty, or are you presently being investigated or charged with any felony or misdemeanor directly relating to EIBI services, behavior analysis services or public health and safety?

   **YES_____ NO_____ Attach an explanation for "YES" responses**.

4. Have you read, are you in compliance with, and do you agree to continued compliance with all current PDD Program rules, regulations, and standards as may be revised?

   **YES_____ NO_____**

5. During the previous year for each child on your case load, have you submitted the child's Program Checklist to that child's Case Manager the previous month's reports no later than the 15th day of the following month (e.g. March reports must be received no later than April 15th) and maintained documentation of that submission?

   **YES_____ NO_____**

6. During the previous year for each child on your case load, have you submitted to the Case Manager the previous quarter's Data Reports (containing cumulative graphs of target areas demonstrating progress or areas of concern) no later than the 15th day of the month that immediately follows the quarter (e.g. the quarterly report for April, May and June must be received no later than July 15th) and maintained documentation of that submission? **(Note: the quarter begins with the child's assessment date)**

   **YES_____ NO_____**

7. During the previous year for each child on your case load, have you submitted to the child's Case Manager and the Autism Division the Assessment of Basic Language and Learning Skills-Revised (ABLLS-R) semi-annually per the initial assessment date. The Case Manager and the Autism Division must have received the completed ABLLS-R no later than 15 days after the end of the semi-annual period (e.g. the annual period runs from April 1, 2007 – April 1, 2008; the September 30, 2007 semi-annual ABLLS-R must be received no later than October 15, 2007).

   **YES_____ NO_____**

8. During the previous year for each child on your case load, have you submitted to the Case Manager and the Autism Division the completed PPVT-IV, EVT-II and Vineland-II no later than 15 days after the end of the annual assessment period (e.g. reports from the annual assessment period of April 15, 2007 – April 15, 2008 must be received no later than April 30, 2008).

**YES_____ NO_____**

9. Do you affirm that to the best of your knowledge no more than two (2) hours per month for Consultant Off-Site Services have been billed for any child on your case load?

   **YES_____ NO_____**

10. Do you affirm that all Off-Site services for children on your case load have been accurately documented?

    **YES_____ NO_____**

11. Do you affirm that you have submitted with the required Monthly Report to the Case Manager a summary identifying specifically what off-site services were provided for the child during the month?

    **YES_____ NO_____**

12. Do you affirm that you have provided the required training (initial and annual) for family members and therapists for each consumer on your case load funded through the PDD Waiver/State Funded Program?

    **YES_____ NO_____**

**CONTINUING EDUCATION**

Do not send documentation. A 10% sample of applicants for recertification will be selected at random to submit documentation of continuing education. Certificants who are selected as part of the 10% sample will be sent a letter requesting this documentation and they will have 15 days to submit their documentation.

Continuing Education **(List the number of hours for each type of CE.)**

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|---|---|---|---|
| **Type 1 –** College or University Course(s) related to ASD and/or ABA | # | **Type 5–** Passing BACB Certification Exam | # |
| **Type 2 –** Approved BACB Provider Events or BACB Event | # | **Type 6 –** Educational Training Opportunities Offered by DDSN and/or DHHS | # |
| **Type 3 –** Non-approved events (Maximum of 25% of total required CE) | # | **Type 7 –** National Recognized Conferences/Workshops Focusing on ASD | # |
| **Type 4 –** Instruction of Type 1 or 2 (Maximum of 25% of total required CE) | # | **Type 8 –** National Recognized Conferences/Workshops Focusing on ABA | # |

Total Hours: _____ (All Consultants must obtain 24 CE hours for the three year period)

**ATTESTATION**

By signing, you acknowledge and affirm: (1) that you have carefully read and understand the PDD Waiver manual standards and requirements that pertain to EIBI providers; (2) that you agree to abide by these standards and requirements; and (3) that the information you have provided in this application and in the attached documentation is true and correct to the best of your knowledge.

Printed Name: _____

Signature: _____

Date: _____



**MAIL THIS APPLICATION TO:**

Daniel Davis/Autism Division ♦ 3440 Harden Street, P.O. Box 4706 ♦ Columbia, South Carolina 29240